SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Short Term Care Revisions	SERFF Tr Num: WAKE-126262183	State: Arkansas
TOI: H13I Individual Health - Short Term Care	SERFF Status: Closed-Approved-Closed	State Tr Num: 43309
Sub-TOI: H13I.002 Nursing Home	Co Tr Num: AMHSTCRAR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Toni Hess	Disposition Date: 09/03/2009
	Date Submitted: 08/24/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: UCT	Status of Filing in Domicile: Authorized
Project Number: AMHSTCRAR	Date Approved in Domicile: 06/16/2009
Requested Filing Mode: Informational	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 09/03/2009	Explanation for Other Group Market Type:
	State Status Changed: 09/03/2009
Deemer Date:	Created By: Toni Hess
Submitted By: Toni Hess	Corresponding Filing Tracking Number:

Filing Description:

Short Term Care Insurance Outline of Coverage – Form Number STC OC 1/09 REV

Short Term Care Insurance Application – Form Number STC APP 1/09 AR REV

FOR USE WITH:

Short Term Care Insurance Policy Form Number STC 1/09 – Approved 8/5/09

These forms are being submitted for use with the Short Term Care Insurance Policy approved in your state. The date is noted above.

SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

The two forms were approved under the filing however have been revised as follows:

It was noted the Home definition in the outline was not the same as the definition in the Policy. The outline's definition reflected "assisted living facility". Reference to assisted living facility has been deleted from the definition in the outline.

The application approved was for an applicant and spouse. The application being submitted is for an individual. Due to administrative procedures, the Company cannot accommodate two names on one policy information file. Any information requested on behalf of a spouse has been deleted. A question has been added asking whether or not a spouse is applying for the same type of policy and their name so the Company can provide the spousal discount if applicable.

Please be advised the revisions to the two forms will have no impact on the rates.

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration of this filing for The Order of United Commercial Travelers of America.

Company and Contact

Filing Contact Information

Toni Hess, Compliance Consultant	toni.hess@hesscc.com
931 Clarmont Avenue	215-485-2582 [Phone]
Bensalem, PA 19020	

Filing Company Information

(This filing was made by a third party - WAS01)

The Order of United Commercial Travelers of America	CoCode: 56383	State of Domicile: Ohio
1801 Watermark Drive, Suite 100	Group Code: -99	Company Type:
P.O. Box 159019	Group Name:	State ID Number:
COLUMBUS, OH 43215-8619	FEIN Number: 31-4273120	
(800) 848-0123 ext. [Phone]		

Filing Fees

SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	$20 for each form - no policy being filed Two forms being submitted
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	$40.00	08/24/2009	30064924

SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/03/2009	09/03/2009

SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

Disposition

Disposition Date: 09/03/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

Form Schedule

Lead Form Number: STC OC 1/09 REV

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/03/2009	STC OC 1/09 REV	Outline of Coverage	Outline of Coverage	Initial		41.400	STC OC 109 REV.pdf
Approved-Closed 09/03/2009	STC APP 1/09 AR REV	Application/ Enrollment Form	Application	Initial		40.000	STC APP 109 AR REV.pdf

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA
1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OH 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

SHORT TERM CARE INSURANCE POLICY

OUTLINE OF COVERAGE
POLICY FORM STC 1/09

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY IS NOT A LONG TERM CARE INSURANCE POLICY ACCORDING TO STATE INSURANCE LAWS AND REGULATIONS

READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

LIMITED BENEFIT INSURANCE COVERAGE - The policy is designed to provide benefits for convalescent care in a facility that provides nursing care or other benefits specified in the policy.

BENEFITS

Facility Confinement Benefit

Once the Elimination Period is satisfied under the policy, we will pay the actual charges incurred up to the Maximum Daily Benefit Amount for each day you are confined in a Facility.

Bed Reservation Benefit

Once the Elimination Period is satisfied, we will pay the actual charges incurred up to the Maximum Daily Benefit Amount for fees charged to reserve a bed by a Facility when You are absent for any reason during the course of an eligible confinement. This benefit is limited to twenty-one (21) days per Period of Care. Benefits payments will count toward the Maximum Benefit Period.

Qualifying For Benefits

To receive benefits under the policy, the following requirements must be met:

1. The policy must be in force on the date Covered Services are received; and
2. A Physician must certify that:
   a) You are unable to perform at least two (2) Activities of Daily Living without Hands On Assistance or Standby Assistance; or
   b) You have a Cognitive Impairment and require Substantial Supervision.

Limitations On Benefits

Benefits under the policy will not be paid during the Elimination Period and are subject to the Lifetime Maximum Benefit Period.

Important Definitions

Activities of Daily Living means the basic human functions required for you to remain independent. For the purposes of the policy, Activities of Daily Living are as follows: bathing, continence, dressing, eating, toileting and transferring.

Cognitive Impairment means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning or judgment as it relates to safety awareness. Cognitive Impairment is measured by clinical evidence and standardized tests and is based on your impairment as indicated by loss in the following areas:

1. short or long term memory; or
2. recognition of who or where You are; or time of day, month or year; or your deductive or abstract reasoning.

Covered Services means confinement in a Facility (as defined in the policy). Covered Services will be modified to include in Home Health Care, if the optional Home Health Care Rider is listed on the policy schedule page and the premium for the rider is paid.

Elimination Period means the number of Facility Confinement days (or any combination of Facility Confinement care days and Home Health Care days, if the Home Health Care Rider is elected), for which benefits are not payable under the policy. Days counted toward the Elimination Period need not be consecutive. The Elimination Period is shown on the Policy Schedule Page. The Elimination Period must be satisfied only once during the Insured's lifetime and can only be satisfied by days on which you incur charges for which payment would be made under the policy if there were no Elimination Period.

Facility means a facility that provides ongoing care and related services to at least five (5) inpatients in one (1) location and meets all of the following standards:

1. it is licensed by the appropriate licensing agency, if the state in which it operates licenses such facilities; and
2. it is operated pursuant to law; and
3. it is primarily engaged in providing, in addition to room and board accommodations, nursing care (skilled, intermediate or custodial) by or under the supervision of a duly licensed Physician; and
4. it provides twenty-four (24) hour a day care and services sufficient to support needs of persons who require nursing care; and
5. it has appropriate methods and procedures for handling and administering drugs and biologicals; and
6. it maintains a daily medical record of each patient.

A Facility includes a long term care facility, a nursing home facility or an assisted living facility.

A Facility IS NOT: a hospital, Your Home, and Alzheimer's Facility, an adult foster care facility, a facility or part thereof used primarily for rest; or a home or facility for the aged or for the care and treatment of drug and alcohol abuse; or a home or facility used for the care and treatment of Mental or Nervous Disorders or educational care.

Hands On Assistance means the physical assistance of another person without which you would be unable to perform an Activity of Daily Living.

Home means your private residence, home for the retired or aged, or a place providing residential care, including an adult congregate living facility or a personal care facility.

Lifetime Maximum Benefit Period means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under the policy. The Lifetime Maximum Benefit Period is shown on the Policy Schedule Page and is equal to three (3) times the Maximum Benefit Period.

Maximum Benefit Period means the maximum number of Facility confinement days (or any combination of Facility confinement days and Home Health Care days, if the Home Health Care Rider is elected) for which benefits are payable under the policy per Period of Care. The Maximum Benefit Period is shown on the Policy Schedule Page.

Maximum Daily Benefit Amount means the maximum amount payable for any one day of benefits provided under the policy. The Maximum Daily Benefit Amount is shown on the Policy Schedule Page.

Important Definitions

Period of Care means the first day benefits are paid for a Facility confinement (or the first day benefits are paid for either, a Facility confinement or Home Health Care, if the optional Home Health Care Rider is elected). A Period of Care ends, if for a period of 180 consecutive days:

1. You have not met the requirements for benefit eligibility; and
2. Your Physician certifies that You did not require and have not been advised to be confined in a Facility or to receive Home Health Care for the 180 day period; and
3. You have not been confined in a Facility or received Home Health Care for the 180 day period.

Physician means a licensed practitioner of the healing arts operating within the scope of his or her license who is other than a member of your immediate family.

Standby Assistance means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an Activity of Daily Living.

Substantial Supervision means continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations by another person that is necessary to protect You from threats to your health or safety.

Exclusions: We will not pay benefits for that portion of any expense which is:

1. caused by Mental or Nervous Disorder, without demonstrable organic disease **(NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THIS POLICY AS ANY OTHER SICKNESS);** or
2. caused by alcoholism or drug addiction; or
3. caused by illness, treatment or medical conditions arising out of:
   a) war or act of war (whether declared or undeclared); or
   b) participation in a felony, riot or insurrection; or
   c) service in the armed forces or units auxiliary thereto; or
   d) suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury; or
4. for treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
5. for services provided by a member of Your Immediate Family ; or
6. for services for which no charge is normally made in the absence of insurance; or
7. for care received outside the United States or its territories.

Guaranteed Renewable For Life - Premium Subject To Change. The policy is renewable as long as you live, provided you continue to pay premiums when due. At no time while you continue your policy in force, may we place any restrictive riders on your coverage. We cannot cancel or refuse to renew the policy. Your premiums will not increase due to a change in your age or health. We can, however, change your premiums but only if we change premiums for all policies in the same premium class with the same policy form number in your state. We must give you at least thirty (30) days written notice before we change your premiums.

Premium.

You have selected the following benefits for the Base Policy:

Maximum Daily Benefit Amount	**$_____**
Elimination Period	**_____Days**
Maximum Benefit Period	**_____Days**
Lifetime Maximum Benefit Period	**_____Days**

Check **[X]** for one of the following **Base Policy Option and Optional Riders** applied for:

[ ] The annual premium for the **Base Policy Form** **$** _____

[ ] The annual premium for the **Base Policy Form With the Compound Inflation Protection Rider** **$** _____

[ ] The annual premium for the **Base Policy Form With the Guaranteed Purchase Option Rider** **$** _____

[ ] **Home Health Care Rider** **$** _____

TOTAL ANNUAL PREMIUM **$** _____

The Order of UNITED COMMERCIAL TRAVELERS OF AMERICA
Home Office: 1800 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
(614) 487-9680, Toll-free: (800) 848-0123, Fax: (614) 487-9675 www.uct.org

APPLICATION FOR SHORT TERM CARE INSURANCE POLICY

Requested Effective Date of Policy

APPLICANT				**APPLICANT'S ADDRESS**
Last	*First*		*MI*	*Street:*
AGE	**DATE OF BIRTH**		**SEX**	
	Month	*Day*	*Year*	☐ Male ☐ Female
SOCIAL SECURITY NUMBER				*City:*
				State: *Zip Code:*
				Area Code: *Telephone Number:*

Underwriting Risk Classification Question

Have you used any form of tobacco in the past two years? ☐ Yes ☐ No

Are you a member of The Order of United Commercial Travelers of America? ☐ **Yes** ☐ **No**

Council Name:_____ **Council Location (City & State)** _____

Is your spouse also applying for the Short Term Care Insurance Policy? ☐ **Yes** ☐ **No**
If yes, please complete:

Last Name: _____ *First Name:* _____

HEALTH QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS, YOU ARE NOT ELIGIBLE FOR COVERAGE.

1.	Do you require assistance or supervision of any kind to perform activities of daily living such as walking, eating, bathing, dressing, transferring or toileting?	☐ Yes	☐ No
2.	Do you require assistance with shopping, housekeeping or cooking?	☐ Yes	☐ No
3.	During the past two (2) years have you:		
	(a) Been a resident of an assisted living facility or personal care home or been confined to a nursing home, home for the aged, or any facility providing assistance with activities of daily living?	☐ Yes	☐ No
	(b) required any assistance with mobility including the use of a walker, multi-pronged cane, walking aids, wheelchair, or scooter?	☐ Yes	☐ No
4.	Are you currently bedridden, hospitalized or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No
5.	Within the past two years, have you been advised to have kidney dialysis, had a heart attack, stroke or heart valve surgery, been recommended to have surgery but not had such surgery, had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse?	☐ Yes	☐ No
6.	Have you had or been told by your physician you needed amputation due to disease, you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes	☐ No
7.	Do you receive Federal, state or local government financial assistance in any form, such as Supplemental Security Income or Medicaid?	☐ Yes	☐ No
8.	Are you an insulin dependent diabetic?	☐ Yes	☐ No

BENEFIT OPTIONS

☐ **Short Term Care Insurance Policy** **Maximum Daily Benefit Amount:** **$**_____ **Elimination Period** ☐ **0 Days** ☐ **20 Days**

Maximum Benefit Period ☐ **100 Days** ☐ **200 Days** ☐ **360 Days**

Optional Riders ☐ **Home Health Care** ☐ **Compound Inflation Protection**

REPLACEMENT INFORMATION (MUST BE COMPLETED)

1. Do you have another insurance policy in force (including health care service contract or health maintenance organization contract)? ☐ Yes ☐ No
2. Did you have another limited benefit policy in force during the last six (6) months? ☐ Yes ☐ No
   If yes, with which company: (Name and address): _____

_____

Policy Number: _____ If that policy lapsed, when did it lapse? _____

Daily Benefit Amount : $_____ Benefit Period _____

Do you intend to replace any of your medical or health insurance coverage with this policy? ☐ Yes ☐ No
If yes, please read and sign the replacement notice provided by the agent.

AUTHORIZATION
MUST BE COMPLETED AND SIGNED

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance company or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or having any non-medical information concerning me to give The Order of United Commercial Travelers of America (UCT), or its reinsurers, any such information. I understand that I am authorizing The Order of United Commercial Travelers of America (UCT) to receive my health information or prescription drug usage history and my non-medical information. The released information received by The Order of United Commercial Travelers of America (UCT) will remain protected by federal and/or state regulations as long as it is maintained by the health plan.

I hereby apply to The Order of United Commercial Travelers of America (UCT) for a policy to be issued in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. I understand that any change in my health prior to delivery of this policy may be used in the underwriting evaluation process. I have received an outline of coverage for the policy applied for.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ _____

Signature of Applicant **Date**

REASON FOR DISCLOSURE

I understand that the information requested is necessary for evaluation of my application and underwriting of my application for the Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issuance determinations; obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Order of United Commercial Travelers of America (UCT). I understand that failure to provide the authorization to The Order of United Commercial Travelers of America (UCT) *will* result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Order of United Commercial Travelers of America (UCT) in writing at their Home Office: 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619. I understand that such revocation will not have any effect on actions The Order of United Commercial Travelers of America (UCT) took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under the policy. A photocopy of this authorization will be treated in the same manner as the original.

Signature of Applicant **Date**

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Signature	**Date**
Agent's Printed Name	**Agent No.**

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT			
☐ Annual	☐ Semiannual	☐ Quarterly	☐ Monthly EFT

Short Term Care Only Premium	**$**
Home Health Care Rider Premium	**$**
Compound Inflation Protection Rider Premium	**$**
SUBTOTAL	**$**
Less Spousal Discount (If Applicable)	**$**
Less Non-Tobacco Discount (If Applicable)	**$**
TOTAL MODAL PREMIUM	**$**
Modal Fraternal Dues (If Applicable)	**$**
TOTAL MODAL AMOUNT DUE	**$**
TOTAL AMOUNT PAID WITH APPLICATION	**$**

AUTHORITY TO HONOR PREMIUM CHECKS - ATTACH VOIDED CHECK
Deposit Slips NOT Accepted

AUTHORIZATION

IN FAVOR OF: **The Order of United Commercial Travelers of America**
1801 Watermark Drive, Suite 100, Box 159019, Columbus, Ohio 43215-8619.

Name of Bank Customer:

Insured's Name: _____

Account Number: _____ **Routing Number:** _____

To (Name of Bank): _____
Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date	**Signature of Bank Customer**

AUTHORIZATION

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above:

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/03/2009

Comments:

Attachments:

AR - R&R19 Cert H.pdf

AR - R&R49 Cert H.pdf

Readability AR.pdf

CONS NOT.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	09/03/2009

Comments:

Attached Under Form Schedule Tab

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/03/2009
Bypass Reason:	Not applicable to this filing		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	09/03/2009

Comments:

Attached under Form Schedule Tab

		Item Status:	Status Date:
Satisfied - Item:	Authorization Letter	Approved-Closed	09/03/2009

SERFF Tracking Number:	*WAKE-126262183*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*43309*
Company Tracking Number:	*AMHSTCRAR*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*Short Term Care Revisions*		
Project Name/Number:	*UCT/AMHSTCRAR*		

Comments:

Attachment:

Auth (filing) 7-14-09.pdf

ARKANSAS
Rule and Regulation 19 Certification

Title of Form(s)	Form Number
Outline of Coverage	STC OC 1/09 REV
Application	STC APP 1/09 AR REV

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

ARKANSAS
Rule and Regulation 49 Certification

Title of Form(s)	Form Number
Outline of Coverage	STC OC 1/09 REV
Application	STC APP 1/09 AR REV

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
Columbus, Ohio 43215

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	**Form Number(s)**	**Flesch Score**
Outline of Coverage	STC OC 1/09 REV	41.4
Application	STC APP 1/09 AR REV	40.0

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

Signature

Joseph H. Hoffman
Name

Chief Executive Officer
Title

Consumer Notice
The Order of United Commercial Travelers of America

Policyholder Service Office:	**1801 Watermark Drive, Suite 100** **Columbus, Ohio 43215-8619**
Telephone Number:	**800-848-0123**
Name of Agent:	**[Fred Smith]**
Agent Address:	**[123 First Street, Any Town, Arkansas]**
Agent Telephone Number:	**[555-555-1234]**

If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494 or 1-501-371-2460

THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA
1801 WATERMARK DRIVE, SUITE 100, P.O. BOX 159019, COLUMBUS, OHIO 43215-8619
(614) 487-9680 • TOLL-FREE: (800) 848-0123 • FAX: (614) 487-9675 • www.uct.org

July 14, 2009

J. Steven Keck, FSA, MAAA
Wakely Actuarial
34125 US Highway 19 North, Suite 310
Palm Harbor, FL 34684

Dear Mr. Keck:

Wakely Actuarial is hereby authorized to perform filings on behalf of The Order of United Commercial Travelers of America.

Thank you.

Sincerely,

Joseph Hoffman
Chief Executive Officer